# NEW JERSEY MEDICARE SUPPLEMENT UNDER 50 PLAN
# CARRIER MARKET SHARE REPORT

## 2003

This Report must be completed in accordance with the provisions of N.J.A.C. 11:4-23A et seq. and certified to by a duly authorized officer of the Carrier. Reports must be completed and returned on or before March 1 annually. If you have any questions regarding completion of this form, please call 1-800-628-7734. Completed Reports for the calendar year 2003 are to be returned to:

**New Jersey Medicare Supplement Under 50 Plan**
**c/o Pool Administrators Inc.**
**100 Great Meadow Road, Suite 112**
**Wethersfield, CT 06109**

**PART A. CARRIER INFORMATION**

1. Carrier Name: _____

2. Carrier Address:_____

   _____

3. NAIC # (including Group #): _____

4. Is the specifically-named carrier an Affiliated Carrier: _____ yes _____ no

   a. If Yes, is this Report the combined report for all Affiliated Carriers, or for the specifically Named Carrier?

      _____ All Affiliated Carriers' Combined Report

      _____ Specifically Named Carrier's Separate Report

   b. If for all Affiliated Carriers, list the affiliated carriers and attach specifically name Carrier Reports to this Combined Report

      1. _____

      2. _____

      3. _____

**PART B. PERSONAL RESPONDENT INFORMATION**

1. Name: (*Print or Type)*: _____

2. Title:_____

3. Telephone No. _____ Fax No. _____

**PART C. CERTIFICATION**

**I certify that the information provided in the attached Report is accurate and complete and has Been prepared in accordance with the provision of N.J.A.C. 11:4-23A, et seq.**

_____ _____

**Signature of Officer** **Name & Title**

_____

**Date**

**ALL INSURANCE CARRIERS LICENSED IN THE STATE OF NEW JERSEY MUST COMPLETE THIS FILING IN ITS ENTIRETY. IF THERE ARE ZERO PREMIUMS TO REPORT – PLEASE INDICATE "NONE" OR "ZERO" ON THE GRID PAGE**

**THANK YOU**